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AUTHOR Marsh, Pamela T.
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ABSTRACT

Noting that therapeutic nursery programs (TNPs) offer one alternative to mainstream daycare or preschool settings for young children experiencing severe emotional and behavioral difficulties, this study gathered information about TNPs and their services. Response rate to a survey mailed to a nonrandom nationwide sample of 40 programs was 50 percent. The hypothesis was that TNPs would provide services specific to the characteristics of children's presenting problems; findings indicated considerable diversity in the client populations and services provided. The majority of TNPs were located in urban areas (75 percent), with 20 percent in suburban locations. Ninety percent of TNPs provided services to children experiencing a variety of emotional and behavioral difficulties: ADHD was the most common diagnosis (85 percent), Down's Syndrome the least reported (5 percent). TNPs serving children with mental retardation tended to be specific to that population. Most TNPs used a combination of funding sources. Most (75 percent) provided service year-around. Programs requiring family involvement reported a higher rate of attendance problems than overall. Programs providing a meal with psychoeducational presentations to parents did not report attendance difficulties. Forty percent of the TNPs used an eclectic treatment approach, with 20 percent using a cognitive-behavioral approach. Eighty percent of TNPs served at least three client populations. Forty percent of TNPs provided both educational and therapeutic components, with 30 percent providing only a therapeutic component. Teachers were the most frequently involved staff, with social workers, psychologists, occupational and physical therapists also employed. Graduate students were 20 percent of all staff within classrooms. (Contains 16 references.) (KB)

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Therapeutic Nursery Programs:

A Survey of Alternative Preschools

Pamela T. Marsh, BA, MSW

The George Washington University

Center for Professional Psychology

5600 Catholic Church Road

Jefferson, MD 21755

301-371-7619

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Abstract

The number of young children experiencing severe emotional and behavioral difficulties is of great concern to both educators and mental health practitioners. With changing family structures and the increasing use of daycare, it is not uncommon to find children who are unable to successfully adapt to traditional daycare or preschool. Therapeutic Nursery Programs (TNPs) offer one alternative to mainstream daycare or preschool settings. Little research has been conducted regarding the services provided by these programs. The present study gathered a nationwide sample of information about TNPs and their services including demographics, daily operations, family involvement, mental health services, and staffing/educational level. It was hypothesized that a Therapeutic Nursery Program's services would be specific to the characteristics of a child's presenting problems. Results across all areas, indicated considerable diversity in client populations and services provided.

Therapeutic Nursery Programs:

A Survey of Alternative Preschools

In the past twenty years, there has been an increasing number of young children who present severe behavioral and emotional difficulties within daycare and educational settings (Holmes, 1995). With changing family structures and the rise in the use of daycare facilities, it is not uncommon to find children who are unable to remain in traditional daycare and preschool settings. Like older youngsters requiring more "restrictive environments," increasingly these children are removed from the mainstream and placed in therapeutic preschools.

There are numerous reasons for a young child's disruptive and problematic behaviors. Part of the reasons behind these school difficulties may lie in ongoing transient and sometimes unstable environments for children. For example, current public policies may allow young children to remain in fragmented homes with neglectful care, rather than the use of foster care or other residential placements (Holmes, 1995). As well, daycare centers may experience turnover in staff resulting in inconsistent caretaking of children.

Young children also experience stress that may lead to disruptive and difficult behaviors within school settings (Arnold, 1990). Typically, preschoolers' behaviors inform the adults of stressful events in their lives. When tired, a preschooler may regress to immature and disorganized behaviors. Most children, however, are able to recover from the common worries of daily life. Certain stressors such as divorce, hospitalization, or physical and sexual maltreatment, however, extend beyond the realm of normalcy, and may cause children extreme harm and persistent anxiety.

When faced with difficult external situations over which the young child has no control, protective factors appear to be of primary importance (Arnold, 1990; Mash & Dozois, 1996). Protective factors or conditions that shield children from the effects of stressful events offer an opportunity for resilience among troubled youngsters. For example, even if a family is unstable, other important adults may provide alternative consistent and stable relationships in order to protect the youngster from a chaotic home life. Most authors and researchers agree that young children benefit from trusting and consistent social relationships (Chesney & Brusiloff, 1981; Ferber, 1996; Furman, 1999; Lieberman, Weston, & Pawl, 1991; & Wilson, 1988).

Educators and mental health professionals are assessing and monitoring young children, in order to provide early intervention services that function to protect and stimulate emotional and cognitive development (Bennett & Guralnick, 1991). Childhood interventions appear most successful when programs are intense, start at age three or below, involve family members, and maintain consistent and stable staff (Bennett & Guralnick, 1991). It is uncertain as to how these programs actually work, although it appears important to distinguish between different types of participant characteristics, such as culture, type of emotional problem or physical disability (Berlin, O'Neal, & Brooks-Gunn, 1998).

One type of early intervention program, the therapeutic nursery program (TNP), offers an alternative preschool setting that provides such a protective environment and nurtures both educational and emotional development for children ages three to five. Therapeutic nursery programs provide a stable setting in which children may learn how to play, use words to describe their needs and feelings, and interact with an adult

consistently (Ferber, 1996; Holmes, 1995). Started in 1951, the Hana Perkins School in Cleveland, Ohio, spearheaded by Robert Furman, MD and his wife, Erna Furman, was one of the pioneering programs providing psychoanalytic mental health services for young children within an educational setting (Archer & Hosley, 1969). Having served children for nearly 60 years, the program still exists today serving a variety of youngsters.

Currently, TNPs serve diverse populations and use a variety of philosophies of treatment. For example, some programs may utilize the Cornerstone Model in which individual therapy is provided to the child in the classroom, (Kliman, 1975; Lopez & Kliman, 1980), whereas other models provide child psychotherapy outside of the nursery room (Chesney & Brusiloff, 1981). Some facilities use adjunct mental health services in a daycare (Muir & Thorfaksdottir, 1994). Some programs serve distinctly physically disabled children; others focus on abused children (Green & Meersund, 1994; Oates, Gray, Schweitzwer, & Ruth, 1995); and still others offer services to a spectrum of psychiatric disorders.

Although previous research described individual therapeutic nursery programs along with seemingly helpful interventions and case studies, little research has been conducted on the services provided by these programs. The present study sought to gather information on a national level about TNPs and their services, the problems they face, and therapeutic interventions. It was hypothesized that a TNP's services would be specific to a child's presenting symptoms. Under the auspices of the Reginald S. Lourie Center in Rockville, Maryland and George Washington University, a small national

survey project was conducted regarding TNPs including demographic information, pragmatics of operation, family involvement, mental health services, and staffing.

Method

Participants

The sample included 20 TNPs from around the nation. At the time of the study (1998), there were no national organizations or listings of therapeutic nursery programs. Therefore, the survey's selection process was focused, rather than random. Various national organizations were contacted and literature and internet searches were conducted to seek out participants. Finally, practitioners in the Washington, D.C. area with an interest in young children were contacted for knowledge of possible participants. All 40 sites discovered in the process were included in the study.

Procedure

With the input of the Reginald S. Lourie Center's TNP staff, a survey regarding TNPs was developed including five areas: demographics, daily operations, family involvement, mental health services, and staffing/educational levels. In addition to survey questions in each area, comment sections were provided. Participants received a cover letter explaining the survey and its purpose, a copy of the survey, and a self-addressed stamped envelope in which to return the survey form. The following month, calls were made to various sites to encourage participation. Participants were assured that they would receive a copy of the results. Forty sites received surveys with a response rate of 50% (n=20)

Results

In all surveyed areas, results indicated a range of presenting problems and provided services. Unlike the hypothesis that certain programs would provide specific treatments and serve unique populations, results suggested that programs serve a wide range of children with varying problems. One exception to these results was programs catering to the Mental Retardation (MR) population. These programs tended to be more specific in their approach and types of services. Results are divided into sections describing Demographics, Operations, Family Involvement, Mental Health Services, and Staffing follow

Demographics

The majority of the study's TNPs are located in urban areas (75%), while a smaller percentage are in rural (5%) and suburban (20%) locations. Figure 1 shows the various TNP settings. As one might expect, many TNPs exist in nonprofit organization settings (45%), while only 5% are private for profit. Other settings included community mental health centers (5%) (CMHCs), CMHC and Head Start (5%), medical centers (15%), school districts (5%), and university settings (5%). Only 15% of TNPs were free standing.

Figure 1 about here

Although all programs described themselves as TNPs, participants served a wide variety of age groups. For example, 35% of the programs served children from birth to 7 years of age, while an additional 35% served a more traditional preschool population from ages of three to five. The other 30% served older infants to five years of age.

Unlike the original hypothesis, that TNPs would serve special and unique populations, results indicated that 90% of TNPs provided services to children experiencing a variety of emotional and behavioral difficulties. Diagnoses ranged from attachment disorders to Down's syndrome. The most common diagnosis served by the programs was ADHD (85%). ADHD was more prevalent than physical abuse (75%) or sexual abuse (60%). Down's syndrome was the least reported diagnosis (5%). Therapeutic nursery programs serving Mentally Retarded children, however, tended to be specific to that population (10%).

Operations

Like the range of the clients they serve, 75% of TNPs utilize a combination of funding sources including, public funding such as medical assistance, private foundations, health insurance, and school system funding. The most commonly used funding source was public funding (50%).

Similar to traditional daycare settings, TNPs provided services on a year round basis (75%). Of these, 42% offered a separate summer program, while 58% offered an identical program to the regular school year.

Family Involvement

Limited family participation appears to be a problem facing many TNPs. Of the TNPs surveyed, 20% cited attendance problems by families. Many of the programs (65%) used a contract to demonstrate a parent's understanding of a TNP's programs including fee structure, hours of operation, the philosophy of the program, child abuse regulations, and client rights. Of those using contracts, 76% of programs required participation of families. Parents were invited to participate in a variety of programs

including special events, meals, and volunteering within the classroom. Of those programs having required family involvement, the rate of reported attendance problems was even higher (31%) than the overall reported attendance difficulties! Very few programs, however, required participation in any form of psychotherapy (10%). Programs also used handbooks (75%) as a means of explaining their programs and philosophies.

What did appear to encourage family participation was the use of a meal along with a psychoeducational presentation. Fifteen percent of surveyed nursery programs use this as a means of facilitating participation. Of the programs reporting this method, all utilized a contract and 75% required participation in this event. Interestingly, none of these programs reported attendance difficulties.

Mental Health Services

Overall, TNPs tended to use an eclectic treatment approach (40%). Figure 2 displays results of varying treatment philosophies including play and developmental therapies, family systems, behavioral, and cognitive-behavioral methods. Eighty percent of TNPS served multiple populations, defined as three or more client populations. As one might expect, of those programs treating multiple populations, there was a tendency to use an eclectic treatment approach to an even greater degree (50%). Interestingly, 18% of the multiple group, offered only a special education component and no mental health services.

Figure 2 about here

Programs defined as TNPs held a variety of meanings. Some programs centered on children's emotional well-being, while others on educational components. Still others

were oriented toward rehabilitation of physical disabilities. Yet, all of them considered themselves TNPs. Figure 3 shows various program types described as TNPs. Most TNPs are combination programs involving both educational and therapeutic components (40%). To a lesser degree 30% of programs utilize a mental health orientation without an adjunct educational component. As well, some self-described therapeutic preschools use an educational program with consulting mental health services.

Figure 3 about here

Like the diversity of children they serve, TNPs tended to use a variety of methods in dealing with both problematic and positive behaviors. When dealing with negative behavior in the classroom, 80% used a combination of methods. This included verbal limit setting (6.5%), time out (86%), latent meaning (55%), progressive discipline (40%) and physical restraint (66%). Physical restraint was used in extreme cases, with parental permission, and only when the child was in danger of harming himself. Likewise, 70% of surveyed programs indicated that they used a combination of methods to reinforce positive behavior. Methods included token economies (22%), reward systems (79%), verbal praise (79%), physical touch (7%), and acknowledgement of mastery (16%).

Staffing

As one might expect, teachers were the most frequently involved staff within nursery programs (80%) with assistant teachers, a close second (65%). Within educational levels of teachers, 55% had four-year college educations, while 25 % had a two-year college degree. The remaining 25% ranged from doctoral level education to incomplete college degrees. Forty-five percent of programs used social workers in some capacity, while 30% employed psychologists. Programs involving physical rehabilitation

used occupational and physical therapists as well as nurses. Graduate students represented 20% of all staffing within the classroom settings.

Within the mental health arena, programs utilized social workers at the master's level to the greatest extent (58%), while many programs also employed Ph.D. level clinicians (47%). Figure 4 provides further information on the use of various mental health professionals within the sample of programs. In terms of running the programs, 25% of directors were psychologists at the Ph.D. level while 15% were educators prepared at the master's level (M.Ed.). Although social workers were employed by programs to the greatest degree, they constituted only 10% of the directors' positions.

Figure 4 about here

Discussion

Unlike the original hypothesis, TNPs serve a wide variety of children with diverse interventions. Although there are some commonalties between programs, the results of this survey suggest that TNPs are diverse in the areas of demographics, operations, family involvement, mental health services, and staffing. Not surprisingly, 75% of the TNPs are in urban areas. As these areas tend to have greater access to mental health and specialized educational services, the interest in such programs may be greater. Similarly, urban areas have greater numbers of children from fragmented homes and in residential placements, suggesting an increased need for these programs. Since the sample was not random, however, it may be that there are unidentified TNPs in suburban and rural areas, not accounted for by the study.

The apparent diversity of programs also raises another question of how TNPS define themselves. What really is a TNP? Is a TNP a mental health program

serving emotional needs of children or an educational one? The results of the survey tend to support a wide variety of definitions. Perhaps, what is needed is a national organization to assist these early intervention programs in defining themselves. In addition to separating educational versus mental health programs, the organization might encourage communication between programs, as well as, defining the differences between these preschool programs. When asked whether a national organization was necessary, 90% of surveyed programs stated that they would welcome this idea.

Across all treatment programs, the most common child diagnosis was Attention-Deficit Hyperactivity Disorder (ADHD). This result may reflect the current popularity of the diagnosis within both educational and mental health circles. This is a questionable finding, as in young children ADHD is difficult to diagnosis and to separate from conduct or anxiety disorders. It is possible that many of these ADHD diagnoses are comorbid with other psychiatric disorders. What is missing from the data is how programs identify and intervene differentially with the varying symptoms their clients present. What might work for a child with attentional difficulties might be quite different from efficacious interventions with a depressed youngster.

Perhaps reflecting the wide range of problems served by TNPs, the philosophy of treatment tends to be eclectic (40%) and combines three or more treatment modalities. Like current mental health trends, there has been a movement away from traditional psychoanalytic nursery programs to those that are more global and integrative. The survey's results indicate that programs serving MR children used specific cognitive-behavioral and behavioral techniques. The research raises the question of whether

children with other diagnoses might also benefit from specific interventions rather than eclectic measures.

The results of the study suggest that ensuring family participation is problematic for these programs. All programs attempted to involve families on a variety of levels including daily activities, classroom observations, and special events. Even when required through a parental contract, parents continued to have difficulty participating. Would there be a change in parent participation, if parents were required at the outset to participate in a minimum number of therapy sessions? This requirement might be in addition to meal and psychoeducational sessions. The survey's results suggest that contracts alone may be unsuccessful and that additional less threatening supports may encourage parental participation. Another unanswered question is the use of consequences for lack of parental participation? For example, terminating a child's treatment due to lack of parental participation raises ethical questions based upon the safety and well-being of a young child.

This research is not without significant limitations. First, programs participating were not random and may not represent a typical sample of TNPs. Data collection was conducted in 1998, and it may have become easier to locate programs and screen the types of therapeutic nurseries included for future studies. Second, the sample size was small and one should be careful about generalizing the results. Third, although the survey provides general information about varying services, it lacks the specificity to indicate what really works with these youngsters and their families.

Implication

Unlike the original hypothesis, the present therapeutic nursery survey indicates that TNPs are serving quite a diverse population of youngsters and accordingly, utilize a wide variety of interventions. The one exception appears to be programs catering to children suffering from Mental Retardation. These programs tended to use an educational philosophy and were more specific in their interventions.

The research raises some questions about the definition of a therapeutic preschool and how to differentiate between the various types. At the present time, therapeutic preschools include rehabilitation, educational, and mental health facilities. Clearly, these agencies serve different purposes and populations. Perhaps, what is needed is a method of organizing information about these facilities, enhancing communication between groups, and to define the necessary services to be a TNP. A national organization may be a key factor in this process.

More research is needed to understand how effective these programs are in meeting their goals. Rather than case studies, outcome studies assessing cognitive, language and socioemotional factors are needed to truly understand the contributions of these programs. These types of studies would provide us an assessment of efficacious treatment of specific symptoms and diagnoses and successful children and their families. Identification of successful programs and successful families could be the basis for developing criteria for designing and implementing a successful TNP.

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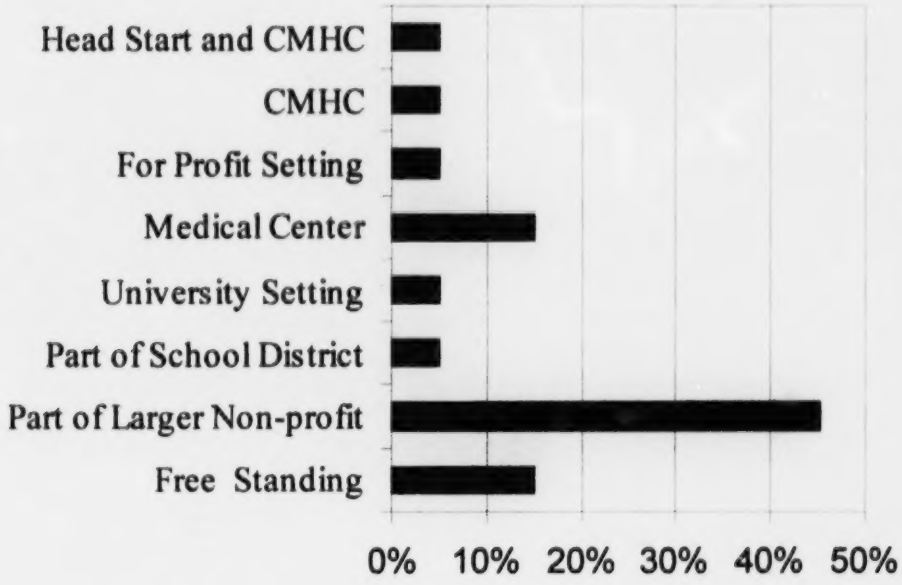

Figure 1. TNP Settings.

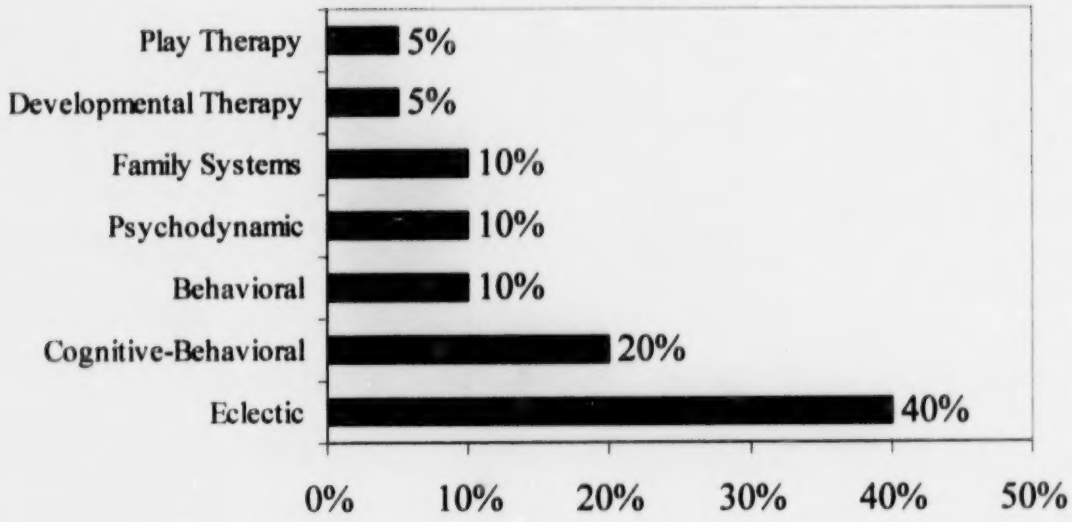

Figure 2. Philosophies of treatment.

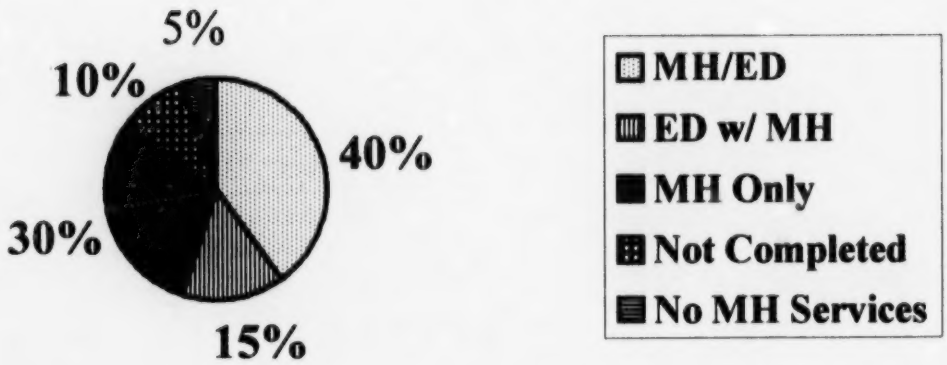

Figure 3. TNP program types.

Figure 4. Educational levels of mental health professionals.